

UNITED STATES DEPARTMENT OF THE INTERIOR
 BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT
 GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

For Public Release

1. OCCURRED

DATE: **13-MAY-2022** TIME: **0011** HOURS

2. OPERATOR: **Cox Operating, L.L.C.**

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: **Seatrax**

REPRESENTATIVE:

TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING
- DAMAGED/DISABLED SAFETY SYS.
- INCIDENT >\$25K
- H2S/15MIN./20PPM
- REQUIRED MUSTER
- SHUTDOWN FROM GAS RELEASE
- OTHER

3. OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR ON SITE AT TIME OF INCIDENT:

8. OPERATION:

4. LEASE: **G01084**

- PRODUCTION
- DRILLING
- WORKOVER
- COMPLETION
- HELICOPTER
- MOTOR VESSEL
- PIPELINE SEGMENT NO.
- OTHER

AREA: **WD** LATITUDE: **28.952287**

BLOCK: **74** LONGITUDE: **-89.683696**

5. PLATFORM: **F**

RIG NAME:

6. ACTIVITY: EXPLORATION(POE)
 DEVELOPMENT/PRODUCTION (DOCD/POD)

9. CAUSE:

7. TYPE:

- EQUIPMENT FAILURE
- HUMAN ERROR
- EXTERNAL DAMAGE
- SLIP/TRIP/FALL
- WEATHER RELATED
- LEAK
- UPSET H2O TREATING
- OVERBOARD DRILLING FLUID
- OTHER _____

INJURIES:

HISTORIC INJURY

OPERATOR CONTRACTOR

REQUIRED EVACUATION 0 1

LTA (1-3 days)

LTA (>3 days) 0 1

RW/JT (1-3 days)

RW/JT (>3 days)

FATALITY

Other Injury

10. WATER DEPTH: **170** FT.

11. DISTANCE FROM SHORE: **16** MI.

POLLUTION

FIRE

EXPLOSION

12. WIND DIRECTION: **NNW**
 SPEED: **15** M.P.H.

LWC HISTORIC BLOWOUT

13. CURRENT DIRECTION: **SE**
 SPEED: **1** M.P.H.

UNDERGROUND

SURFACE

DEVERTER

14. SEA STATE: FT.

SURFACE EQUIPMENT FAILURE OR PROCEDURES

15. PICTURES TAKEN:

COLLISION HISTORIC >\$25K <=\$25K

16. STATEMENT TAKEN:

INCIDENT SUMMARY:

On 13 May 2022, an injury occurred on West Delta (WD) Block 74 "F", a production platform owned and operated by Cox Operating, L.L.C. (Cox). The Injured person (IP), a lead crane mechanic employed by Seatrax with over thirteen years of experience, and Mechanic Helper (MH) with over eleven years of experience, were tasked with removing and replacing the boom tip on the platform's crane. As the IP struck a pin with a hammer to remove the boom tip, the pin flew out causing the boom sections to split and fall. The boom's mid-section landed on the IP's right leg, pinning his leg between the hammer handle and grating. Once the boom section was lifted off the IP's leg, it was revealed that the IP sustained a compound fracture and was losing blood. First Aid was given, and the IP was transported by helicopter to a local hospital where further treatment was provided.

SEQUENCE OF EVENTS:

On 2 May 2022, Seatrax Account Manager (who manages the Cox account) and the IP had a telephone discussion going over the procedures to exchange the boom tip on the Aero-G15 crane at WD 74 F. The IP and MH both stated that they had a full understanding on how to safely complete the boom tip changeout.

On 10 May 2022, the IP and MH traveled offshore to the hub facility, WD 73 D.

On 12 May 2022, the IP and MH changed out the four boom connector pins of the crane's mid-section to heel section. The IP and MH both stated the pins were very difficult to remove, having to repeatedly strike the pins with a sledgehammer in order to drive the pins out.

On 13 May 2022 (day of incident) at 0530 hours, the IP and MH woke up to begin their workday. Both employees stated that had good night's sleep and were well rested that day. They attended the morning safety meeting and ate breakfast.

At approximately 0715 hours, the MH drafted a Job Safety Analysis (JSA) and handed it off to the IP. The JSA was then signed off by the IP without reading it. No discussion of the proper rigging of the mid-section to bridle prior to removing the Seatrax required boom connector safety pins was included in the JSA.

At approximately 0900 hours, the two mechanics traveled by boat from WD 73 D (Hub) to WD 74 F to remove and replace the boom tip on the platform's G-15 American Aero crane. They arrived to WD 74 F at approximately 0945 hours and briefly discussed how they were going to complete the job task. At approximately 1000 hours, they lowered the crane's boom to remove the main block, the aux block, and the anti-two block lines. After breaking for lunch, they returned to work at approximately 1115 hours and the IP lowered the crane's boom down to the deck elevation, placing the boom tip section approximately four feet above the platform deck. Prior to rigging up the mid-section to the bridle, the IP struck the bottom right connector pin with a sledgehammer and with minimal effort the pin came out on the second strike. Assuming that the bottom left pin would be more difficult to remove due to it bearing all the weight, at around 1125 hours, the IP hit the pin once to see if it would budge. To the IP's surprise, the pin was ejected on initial impact, resulting in the boom falling to the grating and pinning the IP's leg between the sledgehammer and grating. The MH immediately radioed the Hub alerting of the incident and requested help. After communication was made, the MH used a nearby pallet jack to free the IP's leg from under the boom. Once the IP's leg was freed from being pinned beneath the boom, the MH noticed blood from the IP's leg and applied a tourniquet with a 1 inch strap and breaker bar to slow the blood loss.

At approximately 1135 hours, the medic arrived and began assessing the situation and observed the IP sitting down with a broken leg. The medic cut away the IP's pant leg to better assess the injury and noticed the IP had sustained a compound fracture to the right leg. A gauze bandage was applied to the open wound and a splint was applied to stabilize the IP's foot in place.

At approximately 1142 hours, a helicopter that was in the area and contracted by Cox, was directed to land at WD 74 F for medical evacuation. The IP and medic boarded the helicopter and proceeded to Terrebonne General Hospital after a quick stop at WD 73 D for refueling. Flight time from platform to hospital was approximately 30 minutes.

At 1305 hours, the helicopter landed at Terrebonne General, and the IP was stabilized and given medication by medical staff.

BSEE INVESTIGATION:

On 13 May 2022 at approximately 1240 hours, the Bureau of Safety and Environmental Enforcement (BSEE) received notice of an incident requiring medical evacuation that occurred at WD 74 F involving a crane mechanic with a severe compound fracture. A BSEE Accident Investigator (AI) was assigned the incident, but unable to conduct an onsite investigation the day of the incident due to unfavorable weather conditions for flight.

On 14 May 2022, two BSEE inspectors arrived at WD 74 F to conduct an initial incident follow-up. The inspectors gathered witness statements, the Job Safety Analysis (JSA) form, crane inspection reports, the Cox incident report, and took photographs of the area where the incident occurred to assist the AI in the investigation.

On 18 May 2022, the BSEE AI contacted the hub platform and spoke with the Medic and MH involved with the incident to gather more details in support of the investigation.

On 2 June 2022, the AI obtained and reviewed the investigation report from Seatrax and compared the report to other documents already acquired. Several factors were observed that contributed to the incident. The JSA sequence did not cover rigging up of the crane's mid-section to the bridle prior to removing pins. Secondly, the Seatrax required boom connecting safety pins were left at the hub. Finally, the JSA was drafted by the MH and signed by the IP without reading it. The IP assumed that the MH had covered all the steps.

CONCLUSIONS:

A lack of communication between the two mechanics contributed to the incident. The MH did not cover the proper steps in the JSA or mention the use of the required Boom Connector Safety Pins, and the IP failed to review the JSA and ensure the proper job sequence and tools were used. According to the incident report provided by Seatrax, both employees acknowledged that they know Seatrax's JSA requirements, yet they did not complete the process as required. The Boom Connector Safety Pins were left at WD 73 D and no attempt to go back to retrieve them before starting the job was made. The mechanics also assumed that the pins would not come out as easy as they did on the day of the incident due to taking more effort the day prior while changing out another section of the boom.

18. LIST THE PROBABLE CAUSE(S) OF ACCIDENT:

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• Human Performance Error - Not following proper procedures: JSA did not cover the proper sequence for performing a boom tip changeout and failed to use the company required Boom Connector Safety Pins.

• Human Performance Error - Inattention to task: Mechanics failed to follow proper procedures and identify the hazards associated with changing out the boom tip.

19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:

• Communication - No or inadequate job instructions provided: According to the incident report obtained by Seatrax, the Lead Mechanic/IP signed the JSA without reading it and having a discussion of the job scope with the MH.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

N/A

N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: NO

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

28. ACCIDENT CLASSIFICATION:

14-MAY-2022

29. ACCIDENT INVESTIGATION

26. INVESTIGATION TEAM MEMBERS:

PANEL FORMED: NO

Nathan Bradley / Derick Lewis /
Terrance Hayes / Brian Wilson /

OCS REPORT:

30. DISTRICT SUPERVISOR:

27. OPERATOR REPORT ON FILE:

David Trocquet

APPROVED

DATE:

10-AUG-2022